Filed for intro on 02/01/95
House Bill_____
By
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Senate Bill No.SB0271
By Womack

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 6, Part 7, to provide for the protection of patients' health, mental health and substance abuse care made available through utilization review agents and managed care systems by a certification process and public disclosure of certain information about their activities.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Title 56, Chapter 6, Part 7 is amended by deleting the part in its entirety and substituting therefore Sections 2 through 13 of this act.

SECTION 2. The title of this act is and may be cited as "The Patient Protection and Utilization Review act of 1995", hereinafter "the act".

SECTION 3. The general assembly hereby finds and declares that the purposes of this act are to:

(A) Promote the delivery of quality health, mental health and substance abuse care in a cost effective manner;

(B) Foster greater coordination among health, mental health and substance abuse care providers, third-party payers and others who conduct utilization review and managed care activities;

(C) Protect patients, employers and health, mental health and substance abuse care providers by ensuring that review agents and review agencies are qualified to perform utilization review and managed care activities and to make informed decisions on the appropriateness of health, mental health and substance abuse care;

(D) Protect patients' health care interests through public access to the criteria and standards used in utilization review and managed care activities; and

(E) Ensure the confidentiality of patients' treatment records in the utilization review and managed care activities in accordance with applicable state and local laws.

SECTION 4. As used in this act, unless the context otherwise requires:

(1) "Certificate" means a certificate of registration granted by the commissioner to a review agent and to a review agency to conduct business as a review agent or review agency in this state.

(2) "Commissioner" means the commissioner of commerce and insurance.

(3) "Health care provider" means any person, corporation, facility or institution licensed or certified by this state to provide health, mental health or substance abuse services, including, but not limited to, a physician, hospital or other health care facility, nurse practitioner, psychologist, social worker, or marital and family therapist, and officer, employee or agent of such provider acting in the course and scope of employment or agency related to the provision of health care services.

(4) "Health care, mental health care, and substance abuse services" means acts of diagnosis, treatment, evaluation or advice or such other acts as may be permissible under the health care licensing statutes of this state.

(5) "Review Agency" means a hospital or non-hospital entity performing utilization review or managed care that is either employed by, affiliated with, or acting on behalf of:

(A) a business entity in this state; or

(B) a third party that provides or administers hospital health, mental health, or substance abuse care benefits to the citizens of this state, including, but not limited to, a health insurer, nonprofit health service plan, health insurance service; or organization, health maintenance organization or preferred provider or similar organization, authorized to offer health, mental health or substance abuse benefits in this state.

(6) "Review Agent" means a person who is employed by a review agency to perform utilization review.

(7) "Utilization Review" is a mechanism for prospective and concurrent review aimed at determining the efficient allocation of health care, mental health care or substance abuse services to be given to a patient or group of patients, which mechanism is to be used in the best interests of the patient.

(8) "Utilization review plan" means a description of the criteria and standards governing utilization review or managed care activities performed by a review agent.

(9) "Adverse Decision" means a utilization review determination made by a review agent that a proposed or delivered health care service:

(1) is or was not necessary, appropriate or efficient; and

(2) may result in noncoverage of the health care service.

There is no adverse decision if the review agent and the health care provider on behalf of the patient reach an agreement on the proposed or delivered health care service.

SECTION 5. Not later than one (1) year after the effective date of this act, the commissioner shall adopt regulations establishing:

(1) Procedures to require that the review agency and the review agents, acting on behalf of the review agency, are qualified to perform utilization review and managed care activities and to make informed decisions on the appropriateness or medical necessity of health, mental health, and substance abuse care. The

commissioner shall promulgate regulations requiring that such procedures developed by a review agency will ensure that the review process complies with all applicable state and federal laws protecting patient confidentiality. In addition, such procedures shall have a system in place which properly identifies the review agent to the treating provider and provides information to the attending health care provider regarding the professional qualifications of the reviewer. Such procedures shall ensure that the attending health care provider shall have access to a written copy of the utilization report prior to such report being deemed final for purposes of denial or refusal to pay for benefits.

(2) The requirement that a review agency provide patients and health care providers with its utilization review or managed care plan, including the specific review criteria and standards, procedures and methods to be used in evaluating proposed or delivered in-patient or out-patient health, mental health or substance abuse services. These plans must be consistent with utilization review standards developed by the relevant national specialty or professional organization when such exists.

(3) The requirement that no determination adverse to a patient or to any affected health care provider shall be made on any question relating to the necessity or justification for any form of in-patient or out-patient or other health, mental health or substance abuse services without prior evaluation and concurrence in the adverse determination by a physician or a panel of other appropriately licensed health care providers which includes at least one (1) physician.

(4) The requirement that any determination regarding in-patient or out-patient or other health, mental health or substance abuse services rendered or to be rendered to a patient which may result in a denial of third-party reimbursement or a denial of pre-certification for that service shall include the evaluation, findings and concurrence of a physician or licensed health care provider who is qualified to provide the service under review or a panel of appropriately licensed health care providers which includes at least

one (1) physician. Such determinations shall reference the specific criteria and standards, including interpretive guidelines, upon which any denial or reduction of coverage is based.

(5) The requirement that no determination that health care services rendered or to be rendered is inappropriate shall be made until a review agent has spoken to the patient's attending health care provider concerning such care.

(6) The requirement that any determination that care rendered or to be rendered is inappropriate shall include the written evaluation and findings of the review agent and such report will be made available to the patient in a reasonable amount of time upon request by the patient.

(7) The requirement that a review agent is reasonably accessible to patients, patients' families, and providers at least five (5) days a week during normal business hours by toll-free telephone and that payment may not be denied for treatment rendered during a period when the review agent is not available.

(8) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual treatment records are followed. Such protection shall include limiting the amount of information requested during a review process. The release of confidential patient information by the attending health care provider to the review agents and review agency shall be limited only to that information which is reasonable and pertinent to determining the necessity of the service under review. Such review shall be kept confidential by the review agent and the review agency pursuant to the ethical principles and laws that pertain to the health care provider's obligation to protect patients. All information released to the review agent and the review agency shall require prior patient authorization.

(9) The requirement that any procedures developed by the review agency pertaining to utilization review shall not interfere with the treatment process.

(10) The requirement that no review agent be permitted to enter a hospital or other treatment setting to interview a patient without prior notification to the patient and such requirement shall include that the interview is consistent with state and federal laws regarding confidentiality of patient records.

(11) The requirement that there be no financial incentive, direct or indirect, that could influence a utilization review determination by the review agency or review agents which shall include a statement of the amount and method of payment for utilization review services together with an identification of every person and entity, no matter how organized, which has a financial interest in the review agency, and amount and nature of the financial interest.

(12) The qualifications to be a review agent.

(13) The qualifications to be a review agency.

(14) The requirements that benefits shall be paid from the onset of services through appeal, and to continue thereafter if the decision on appeal is in favor of the patient.

(15) The requirements that decisions of review agents on behalf of a review agency, regarding continuing mental health care must be made as follows:

(A) In-patient Care: The review system should be based on a realistic time line reflecting well-known and highly predictable patterns of mental health delivery and utilization. An initial review of inpatient care should occur no later than the seventh (7th) session.

(B) Out-patient Care: The review system should be based on a realistic time line reflecting well-known and highly predictable patterns of mental health delivery and utilization. An initial review of outpatient care should occur no later than the twenty-fifth (25th) session.

(16) The requirements that the review agency submit to the commissioner information detailing its procedures for appealing adverse determinations, including, but not limited to, the following requirements:

(A) All adverse decisions must be made by a physician or a panel of other appropriately licensed health care providers which includes at least one (1) physician on the panel. In the event a patient or health care provider seeks a reconsideration or appeals an adverse decision by a review agent, the final determination of the appeal of the adverse decision must be made based on the professional judgment of a physician or a panel of other health care providers with at least one (1) physician on the panel.

(B) That adverse decisions shall be communicated to the aggrieved party and the provider in writing with supporting reasons for non certification or denial within a reasonable time frame. Those time frames shall include:

(i) Inpatient Reviews: Within two (2) working days.

(ii) Out-patient Reviews: Within two (2) working days.

(C) That the entity shall provide an opportunity for the patient or health care provider to present additional evidence for consideration by the appeals committee. Before rendering a final decision, the committee shall review the pertinent medical records of the patient's health care provider and the pertinent records of any facility in which health care services have been provided to the patient.

(D) That in the appeals process, due consideration shall be given to the availability or non-availability of optional health care services proposed by the entity and any hardship imposed by the optional health care on the patient and his/her immediate family.

(17) That treatment that has been authorized may not be subsequently denied retroactively unless:

(A) it is found that the patient did not actually have coverage during the period that treatment was authorized;

(B) the information submitted to the utilization review agency was fraudulent or intentionally misrepresented that patient's condition; or

(C) the treatment was not covered under the policy or contract.

(18) Until the commissioner adopts the above regulations, all of the above provisions in this section shall be deemed to be effective immediately.

SECTION 6.

(a) A review agent who approves or denies payment, or who recommends approval or denial of payment for in-patient or out-patient services provided within the state of Tennessee (health, mental health or substance abuse) or whose review results in approval or denial of payment for hospital or medical services within the state of Tennessee on a case by case basis, may not conduct utilization review or managed care in this state unless the commissioner has granted the review agent a certificate.

(b) The commissioner shall issue a certificate to an applicant who has met all the requirements of this act and all applicable regulations.

(c) A certificate issued under this act is not transferable.

(d) As part of the application, the review agent shall submit information required by the commissioner, including, but not limited to, a certification that there is no financial incentive, direct or indirect that could influence a utilization review determination by the review agent, which shall include a statement of the amount and method of payment for utilization review services.

SECTION 7.

(a) A review agency which approves or denies payment, or which recommends approval or denial of payment for in-patient or out-patient services (health, mental health or substance abuse) or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review or managed care in this state unless the commissioner has granted the review agency a certificate.

(b) The commissioner shall issue a certificate to an applicant who has met all the requirements of the act and all applicable regulations.

(c) A certificate issued under this act is not transferable.

(d) As part of the application, the review agency shall submit information required by the commissioner, including, but not limited to:

(1) A utilization review or managed care plan that includes specific review or managed care standards, criteria and procedures to be used in evaluating delivered or proposed hospital, health, mental health or substance abuse services, and the citations to the scientific literature relied upon in establishing such standards, criteria and procedures.

(2) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual treatment records are followed.

(3) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review or managed care plan including release of information forms to be signed by patients, permitting the review agency to engage in review with the provider.

(4) A list of the third-party payers and business entities for which the review agency is performing utilization review or managed care in this state and a brief description of the services it is providing for each of them, and a statement regarding whether the payment system for such services contains an incentive or contingent fee arrangement.

(5) An identification of every person and entity, no matter how organized, which has a financial interest in the review agency, and the amount and nature of the financial interest.

SECTION 8.

(a) An applicant for a certificate shall:

(1) Submit an application to the commissioner; and

(2) Pay to the commissioner the application fee established by the commissioner through regulation which, for review agencies, shall be no less than one thousand dollars ($1,000).

(b) The application shall:

(1) Be on a form and accompanied by any supporting documentation that the commissioner requires; and

(2) Be signed and verified by the applicant.

(c) The application fees required under subsection (a)(2) of this section shall be sufficient to pay for the administrative costs of the certification program and any other costs associated with carrying out the provisions of this act.

SECTION 9.

(a) A certificate shall expire on the second anniversary of its effective date unless the certificate is renewed for a three-year term as provided in this section.

(b) Before the certificate expires, a certification may be renewed for an additional three-year term if the applicant:

(1) Otherwise is entitled to the certificate;

(2) Pays to the commissioner the renewal fee set by the commissioner through regulation; and

(3) Submits to the commissioner:

(A) A renewal application on the form that the commissioner requires, including a list of all review decisions, especially complaints made to the review agency by patients or providers and a description of how such complaints were resolved; and

(B) Satisfactory evidence of compliance with any requirements under this act for certificate renewal.

(c) Any aggrieved patient or health care provider may file a complaint with the commissioner alleging that a review agent or review agency is not in compliance with this act or the regulations issued thereunder and requesting that the commissioner revoke or suspend the certificate of such review agent or review agency or require that such review agent or review agency comply with the act and/or regulations. The commissioner's decision with respect to such complaint shall be subject to judicial review upon appeal by the patient, health care provider or review agent. If the commissioner fails to render a decision upon a complaint brought by a patient or health care provider within ninety (90) days, the patient or health care provider shall have the right to bring a judicial action to compel the commissioner to revoke or suspend the certificate of the review agent or review agency or to require the review agent or review agency to comply with the act and/or regulations. The filing of a complaint with the commissioner by a provider shall not be just cause for terminating a provider's participation in a provider panel. Providers may be terminated from a panel only in accordance with the contract or policies of the contracting entity.

(d) If the requirements of this section are met, the commissioner shall renew a certificate.

SECTION 10.

(a) The commissioner shall deny a certificate to any review agent or review agency whose application fails to:

(1) Provide information required by the act and regulations adopted pursuant to the act;

(2) Provide satisfactory assurance of the ability to comply with the act and regulations adopted pursuant to the act; or

(3) Demonstrate the availability of a sufficient number of qualified review agents to carry out the utilization review activities of the review agency.

(b) The commissioner may revoke or suspend a certificate if the holder does not comply with performance assurances under this section, violates any provision of this act, or violates any regulation adopted pursuant to the act.

(c) The following procedural requirements shall govern the denial, suspension or revocation of a certificate:

(1) Before denying, suspending or revoking a certificate under this section, the commissioner shall provide the applicant or certificate holder with reasonable time, not to exceed ninety (90) days, to supply additional information demonstrating compliance with the requirements of this act and the opportunity to request a hearing.

(2) If an applicant or certificate holder requests a hearing, the commissioner shall send a hearing notice by certified mail, return receipt requested, at least thirty (30) days before the hearing.

(3) The commissioner shall hold the hearing in accordance with the procedures set forth under relevant state law.

(d) Nothing in this section shall be deemed to deprive a patient or health care provider of any other cause of action available under state law.

SECTION 11. The commissioner shall establish reporting requirements to:

(1) Evaluate the effectiveness of review agents and review agencies, which evaluation shall include, but not be limited to, the results of all health, mental health and substance abuse reviews whether benefits were denied or reduced by the payer, the

number and results of any appeals and any complaints filed in court stating the cause of action that had arisen.

(2) Determine if the utilization review or managed care programs are in compliance with the provisions of this act and applicable regulations.

SECTION 12. A review agent or a review agency or any of its employees may not disclose or publish individual treatment records or any other confidential information obtained in the performance of review or managed care activities.

SECTION 13.

(a) Whenever the commissioner has reason to believe that a review agent or review agency subject to this part has been or is engaged in conduct that violates this part, the commissioner shall notify the review agent or review agency of the alleged violation. The review agent or review agency shall have thirty (30) days from the date the notice is received to respond to the alleged violation.

(b) If the commissioner believes the review agent or review agency has violated this part, or is not satisfied that the alleged violation has been corrected, the commissioner may conduct a contested case hearing on the alleged violation in accordance with the Administrative Procedures act, compiled in title 4, chapter 5.

(c) If, after hearing, the commissioner determines that the review agent or review agency has engaged in violations of this part, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the review agent or review agency a copy of the findings and an order requiring the review agent or review agency to cease and desist from engaging in the violations. The commissioner may also, at the commissioner's discretion, order:

(1) Payment of a penalty of not more than ten thousand ($10,000) dollars in the aggregate for a violation that has occurred with such frequency as to indicate a general business pattern or practice; or

(2) Suspension or revocation of the authority to do business in this state as a review agent or review agency if the review agent or review agency knew the act was in violation this part and repeated the act with such frequency as to indicate a general business pattern or practice.

(d) In addition to any other kind of punishment set forth in this act, a review agent or review agency who violates any provision of this act or any regulation adopted under this act or who submits any false information in an application required by this act is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding five thousand dollard ($5,000). Each day a violation is continued after the first conviction is a separate offense.

SECTION 14. The commissioner shall issue an annual report to the governor and the legislature concerning the conduct of utilization review and managed care in the state. Such report shall include: a description of utilization and managed care programs and the services they provide; the type of criteria and standards used to perform utilization and managed care review; the feasibility of utilization and managed care review; an analysis or the previews and especially complaints filed against private review agents by patients or providers; and an evaluation of the impact of utilization review and managed care programs on patient access to care.

SECTION 15. This act shall take effect upon becoming law, the public welfare requiring it.

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